STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES
SUITABLE FOR USE IN THE HOME

NMAP covers medical supplies listed in the coverage criteria and procedure code list when prescribed for medical care in the client's home. Items not specifically listed may not be covered by NMAP. Coverage for medical supplies does not generally include clients residing in nursing facilities or ICF/MR's.

NMAP does not cover, as medical supplies, personal care items such as non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc. NMAP does not cover, as medical supplies, oral or injectable over-the-counter drugs and medications.

NMAP covers orthotic devices when medically necessary and prescribed to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body. Coverage includes braces, orthopedic shoes and shoe corrections, lumbar supports, hernia control devices, and similar items. NMAP covers prosthetic devices when medically necessary and prescribed to replace a missing body part. Orthotics and prosthetics are covered for clients residing in nursing facilities and ICF/MR's. NMAP does not cover external powered prosthetic devices.

NMAP covers only one pair of orthopedic shoes at the time of purchase. Except when size change is necessary due to growth and/or when diagnosis indicates excessive wear, NMAP allows only one pair of shoes in a one-year period. Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet.

Prior authorization is required of payment of rental and purchase of the items listed in state regulations as requiring prior authorization.

Telehealth: Medical equipment, supplies, orthotics and prosthetics furnished by durable medical equipment suppliers and pharmacies are not covered when provided via telehealth technologies.

ATTACHMENT 3.1-A
Item 7d
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH SERVICES - PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY AND AUDIOLOGY

Services for Individuals Age 21 and Older: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals age 21 and older as a Home Health Agency service only when the following criteria is met. The services must:

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
   a. The services must be restorative when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time;
   b. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
   c. The services must have been recommended in a Department-approved individual program plan (IPP); or
   d. The services must have been recommended in an individual education plan (IEP) or an individual family service plan (IFSP).

These therapies for adults (age 21 and older) are a Home Health Agency Service only when there is no other method for the client to receive the service. Services must be prior authorized by Central Office staff. Substantiating documentation must be attached to the claim.

Services for Individuals Age 20 and Younger: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals birth to age 20 as a Home Health Agency service when the following criteria is met. The services must:

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
   a. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
   b. The services must have been recommended in a Department-approved IPP; or
   c. The services must have been recommended in an individuals education plan (IEP) or an individual family service plan (IFSP).

Telehealth: Home health physical therapy, occupational therapy, speech pathology and audiology services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional services are excluded.

Transmittal # MS-00-06

Supersedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-93-15

ATTACHMENT 3.1-A
Item 8
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PRIVATE DUTY NURSING SERVICES

NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older:

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.

2. Per diem reimbursement for all other in-home nursing services shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

3. Telehealth: Private duty nursing services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional services are excluded.

Transmittal # MS-00-06

Supersedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-93-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

Community mental health centers must be licensed and approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA), Commission on Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF). Certification through the Nebraska Department of Health and Human Regulation and Licensure will fulfill the accreditation requirements. Services provided by community mental health centers are limited to medically necessary acute psychiatric services.

Day treatment services are limited to a half-day or full-day rate, established on the basis of each facility's cost report which is reviewed annually.

Prior authorization is not required for medically necessary outpatient psychotherapy services.

Testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

Services Provided in Ambulatory Surgical Centers: NMAP covers facility services provided in ambulatory surgical centers (both free-standing and hospital-affiliated) under the following limitations.

The "facility fee" includes payment for services and items provided by an ASC in connection with a covered surgical procedure.

Covered surgical procedures include the procedures on Medicare's list of covered ASC procedures and state-defined procedures, which includes tubal ligations, vasectomies, and certain dental services.

The ASC may also provide services other than those included under the facility fee. These services are limited under the appropriate category (durable medical equipment, medical supplies, ambulance services, etc.) listed elsewhere in the Title XIX Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

ABORTIONS:

Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

Telehealth: Clinic services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - DENTAL SERVICES

PRIOR AUTHORIZATION: NMAP requires prior authorization for certain dental services. Prior authorization must be obtained before the service is provided. Diagnostic services, as defined in state regulations, do not require prior authorization. Pre-payment authorization for emergencies and other circumstances beyond the provider's control (insurance coverage, etc.) will be reviewed by Medicaid Division staff.

COVERED SERVICES: NMAP defines dental services as any diagnostic, preventive, or corrective procedures provided by or under the supervision of a licensed dentist. Covered procedures are specified in state regulations.

DIAGNOSTIC DENTAL SERVICES: NMAP covers diagnostic dental services as defined in state regulations, as amended. This includes exams, radiology, prophylaxis, topical application of fluoride, and diagnostic casts. Exams are covered once each year on a routine basis for clients age 21 and older. For clients who are eligible for HEALTH CHECK (EPSDT), exams are allowed every 6 months or more often if medically necessary. Interperiodic dental exams will also be considered appropriate to determine the existence of suspected conditions. When a patient is referred to another dentist or specialist, NMAP covers one exam by the second dentist or specialist.

Keep No change

ORAL SURGERY: Oral surgery, as defined by HCPCS, is covered as a physician service.

HOSPITALIZATION FOR DENTAL SERVICES Dental services must be provided at the least expensive appropriate place of service. Payment for hospitalization, either outpatient or in an Ambulatory Surgical Center, for dental treatment must be prior authorized by the Medicaid Division. Authorization is based on medical necessity rather than dental needs. Emergencies, such as trauma resulting from an accident, do not require prior authorization of payment.

Transmittal # MS-00-06

Supercedes Approved MAR 1 ? 2001 Effective JUL 1 2000

Transmittal # MS-93-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - DENTAL SERVICES

For dental services provided in a hospital (inpatient, outpatient, or in an Ambulatory Surgical Center), the dentist shall request prior authorization of payment for the dental procedure from the Medicaid Division.

DENTURES: NMAP covers dentures only when the prior authorization request indicates masticatory deficiencies likely to impair the general health of the client. Other factors considered are age: school status, employment status, rehabilitation potential of the client, and psychological implications. NMAP does not cover dentures when:

1. A repair will make the existing denture or partial wearable.
2. A reline will make the existing denture or partial wearable.
3. A rebase will make the existing denture or partial wearable.
4. Dental history reveals that any or all dentures or partials made in recent years have been unsatisfactory to the client.
5. Denture or partial is lost, and was purchased by NMAP as a replacement for a previously lost denture or partial.

PARTIALS: For clients age 21 and older, NMAP only considers authorization of partial dentures for replacement of anterior teeth. NMAP defines the front eight teeth on each arch as anterior teeth for partials. NMAP may authorize a flipper type partial, or acrylic partial as determined most appropriate by consultant review criteria. NMAP does not cover cast partials for clients age 21 and older.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - DENTAL SERVICES

For clients age 20 and younger, NMAP considers authorization of partial dentures if the client does not have adequate occlusion. Adequate occlusion, for clients age 20 and younger, is determined to be second bicuspid through second bicuspid or a combination of two occluding molars with no missing anterior teeth. NMAP requires that cast clasps be used on partial dentures.

COSMETIC SERVICES: NMAP does not cover cosmetic dental services.

RADIOLOGY: NMAP limits coverage of radiology to those procedures necessary to make a diagnosis. The radiograms must show all areas where treatment is planned. A complete series of radiograms is covered once every three years.

ENDODONTIA: NMAP covers endodontia for anterior and posterior permanent teeth when the prior authorization request of submitted x-rays substantiates medical necessity.

PERIODONTAL TREATMENT: All periodontal treatment must be prior authorized by the Medicaid Division. Covered periodontal services include those procedures necessary for the treatment of the tissues supporting the teeth.

Telehealth: Dental services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

Attachment 3.1-A
Item 11a
Applies to both categorically
and medically needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PHYSICAL THERAPY

NMAP covers physical therapy services when the following conditions are met:

1. The services must be prescribed by a physician;
2. The services must be performed by, or under the direct supervision of, a licensed physical therapist;
3. The services must be restorative; and
4. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

NMAP does not cover physical therapy if the expected restoration potential is insignificant in relation to the extent and duration of the services required to achieve the potential.

Exception: NMAP covers physical therapy services for EPSDT eligibles when the following conditions are met:

1. The services must be prescribed by a physician;
2. The services must be performed by, or under the direct supervision of, a licensed physical therapist; and
3. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

Telehealth: Physical therapy services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

Transmittal # MS-00-06

Supercedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-90-14

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OCCUPATIONAL THERAPY

NMAP covers occupational therapy services provided by independent therapists under the following conditions.

The therapist must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure. If services are provided by an OT assistant under the supervision of an OT, the assistant must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure. If services are provided outside Nebraska, the provider must be licensed in that state.

Occupational therapy is defined as improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning when functions are impaired or lost; or preventing, through early intervention, initial or further impairment or loss of function.

NMAP covers OT services when the following conditions are met. The services must be:

1. Prescribed by a physician;
2. Performed by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist;
3. Restorative; and
4. Reasonable and medically necessary for the treatment of the client's illness or injury.

NMAP covers orthotic appliances or devices when medically necessary for the client's condition. NMAP does not reimburse an occupational therapist for orthotic devices or appliance which do not require customized fabrication by the therapist.

Exception: NMAP covers occupational therapy services for EPSDT eligibles when the following conditions are met. The services must be:

1. Prescribed by a physician;
2. Performed by a licensed occupational therapist or a licensed occupational therapy assistant under the supervision of a licensed occupational therapist; and
3. Reasonable and medically necessary for the treatment of the client's illness or injury.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - OCCUPATIONAL THERAPY

Telehealth: Occupational therapy services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care are excluded.

Transmittal # MS-00-06

Supercedes Approved MAR [illegible] Effective JUL 1 2000

Transmittal # new page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS

To be covered by NMAP, speech pathology and audiology services must be prescribed by a licensed physician and performed by a licensed speech pathologist or audiologist. The speech pathologist or audiologist must be in constant attendance. The physician's orders must be for no more than 30 days, with documentation of the patient's progress and a recertification of the physician's order every 30 days or more frequently if the patient's condition necessitates.

In addition, the services must meet at least one of the following conditions:

1. The services must be an evaluation;
2. The services must be restorative speech pathology with a medically appropriate expectation that the patient's condition will improve significantly within a reasonable period of time; or
3. The services must have been recommended in a Department-approved individual program plan (IPP); or
4. The services must be necessary for an individual with an augmentative communication device.

NMAP covers speech pathology and audiology services when the following conditions are met:

1. The services must be prescribed by a physician;
2. The services must be performed by, or under the supervision of, a licensed speech pathologist or audiologist;
3. The services must be restorative; and
4. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS

NMAP does not cover speech pathology and audiology services when the expected restoration potential is insignificant in relation to the extent and duration of the services required to achieve the potential.

Exception: NMAP covers speech pathology and audiology services for EPSDT eligibles when the following conditions are met:

1. The services must be prescribed by a physician (Exception: Audiology screening services for EPSDT eligibles do not require a physician's prescription);
2. The services must be performed by, or under the supervision of, a licensed speech pathologist or audiologist; and
3. There is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time or the services are recommended in a Department-approved individual program plan (IPP).

Telehealth: Speech pathology and audiology services are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended. Services requiring "hands on" professional care, such as hearing aid fittings, are excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PRESCRIBED DRUGS

The Nebraska Medicaid Program covers outpatient drugs, in accordance with Sections 1902(a)(54) and 1927 of the Social Security Act, which are covered by a national or State agreement, with the following restrictions or exceptions (as indicated by checkmark).

X A. Prior authorization program which complies with Section 1927(d)(5) of the Social Security Act.

X B. The following drugs are covered, or restricted, as indicated by the checkmark:

X 1. Certain drugs are not covered if the prescribed use is not for a medically accepted indication, as defined by Section 1927(k)(6).

X 2. Drugs subject to restrictions pursuant to an agreement between a manufacturer and this State authorized by the Secretary under 1927(a)(1) or 1927(a)(4).

X C. The following drugs or classes of drugs, or their medical uses, as indicated by a checkmark, are excluded from coverage or otherwise restricted:

X 1. Agents when used for anorexia or weight gain.

X 2. Agents when used to promote fertility.

X 3. Agents when used for cosmetic purposes or hair growth.

___ 4. Agents when used for symptomatic relief of cough and colds.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PRESCRIBED DRUGS

X 5. Agents when used to promote smoking cessation.

___ 6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

X 7. Nonprescription drugs.*

___ 8. Covered outpatient drugs which the manufacturer seeks to require as a condition or sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.

X 9. Drugs described in section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of title 21 of the Code of Federal Regulations (DESI drugs).

___ 10. Barbiturates.

___ 11. Benzodiazepines.

X 12. Liquors.

X 13. Personal care items.

*Note: Only nonprescription drugs indicated as covered on the Nebraska Point of Purchase (NE-POP) System or listed on the Department's Drug Code/License Number Listing microfiche are covered.

Telehealth: Pharmacy services for prescribed drugs are not covered when provided via telehealth technologies.

Transmittal # MS-00-06

Supercedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-95-7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS: DENTURES

See Attachment 3.1-A, Item 10, Page 2. – Limitations – Dental Services

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PROSTHETIC DEVICES

The Nebraska Medical Assistance Program covers the purchase or rental of durable medical equipment, medical supplies, orthotics, and prosthetics that meet program guidelines when prescribed by a physician or other licensed practitioner whose licensure allows prescribing these items (M.D., D.O., D.P.M.). To qualify as a covered service under NMAP, the item must be medically necessary and must meet the definitions in state regulations.

NMAP does not cover items that primarily serve personal comfort; convenience; or educational, hygienic, safety, or cosmetic functions; or new equipment of unproven value and/or equipment of questionable current usefulness or therapeutic value.

NMAP does not generally enroll hospitals, hospital pharmacies, long term care facilities; rehabilitation services or centers, physicians, physical therapists, speech therapists, or occupational therapists as providers of durable medical equipment, medical supplies, or orthotics and prosthetics. Home health agencies may provide durable medical equipment and oxygen only.

Durable medical equipment is equipment which:

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home. This generally does no include long term care facilities.

Coverage conditions for individual services are listed with the procedure code descriptions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PROSTHETIC DEVICES

NMAP covers medical supplies listed in the coverage criteria and procedure code list when prescribed for medical care in the client's home. Items not specifically listed may not be covered by NMAP. Coverage for medical supplies does not generally include clients residing in nursing facilities or ICF/MR's.

NMAP does not cover, as medical supplies, personal care items such as non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc. NMAP does not cover, as medical supplies, oral or injectable over-the-counter drugs and medications.

NMAP covers orthotic devices when medically necessary and prescribed to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body. Coverage includes braces, orthopedic shoes and shoe corrections, lumbar supports, hernia control devices, and similar items. NMAP covers prosthetic devices when medically necessary and prescribed to replace a missing body part. Orthotics and prosthetics are covered for clients residing in nursing facilities and ICF/MR's. NMAP does not cover external powered prosthetic devices.

NMAP covers only one pair of orthopedic shoes at the time of purchase. Except when size change is necessary due to growth and/or when diagnosis indicates excessive wear, NMAP allows only one pair of shoes in a one-year period. Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet.

Prior authorization is required of payment of rental and purchase of the items listed in state regulations as requiring prior authorization.

Telehealth: Orthotics and prosthetics furnished by durable medical equipment suppliers and pharmacies are not covered when provided via telehealth technologies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - EYE GLASSES

The Nebraska Medical Assistance Program covers eye examinations, diagnostic services, and other treatment services within program guidelines when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint, or injury.

NMAP covers annual eye examinations for clients age 20 and younger. More frequent exams will also be covered if needed to determine existence of suspected conditions. Eye examinations are recommended beginning at approximately age three.

NMAP covers eye examinations for clients age 21 and older once every 24 months. More frequent eye examinations will also be covered when reasonable and appropriate.

NMAP covers eyeglass frames under the following conditions:

1. The client's first pair of prescription eyeglasses; or
2. When the client's current frame is no longer usable due to -
   a. Irreparable wear/damage;
   b. Loss;
   c. Size change due to growth; or
   d. A prescribed lens change only if new lenses cannot be accommodated by the current frame.

NMAP covers eyeglass lenses under the following conditions:

1. The client's first pair of prescription eyeglasses;
2. When the client's current lenses are no longer usable due to loss, damage, or size change for growth;

STATE PLAN UNDER TITLE XIX ~~OF~~ THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - EYE GLASSES

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3. When new lenses are required due to a new prescription when the refraction correction meets one of the following criteria:
   a. A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
   b. A change in axis in excess of 10 degrees for 0.50 cylinder, five degrees for 0.75 cylinder; or
   c. A change of prism correction of 1/2 prism diopter vertically or two prism diopters horizontally or more.

Lenses must meet the specifications for eyeglass lenses and coverage criteria listed in state regulations.

NMAP covers contact lens services only when prescribed for correction of keratoconus, monocular aphakia, or other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses. NMAP does not cover contact lenses when prescribed for routine correction of vision.

NMAP does not cover:

1. Sunglasses;
2. Multiple pairs of eyeglasses for the same individual (for example, two pairs of eyeglasses in lieu of bifocals or trifocals in single vision frame);
3. Non-spectacle mounted aids, hand-held or single lens spectacle mounted low vision aids, and telescopic and other compound lens systems (including distant vision telescopic, near vision telescopes, and compound microscopic lens systems); and
4. Replacement insurance.

Telehealth: Services requiring "hands on" professional care, such as eye glass fittings, are not covered when provided via telehealth technologies.

ATTACHMENT 3.1-A
Item 13b
Applies to both
categorically and
medically needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - SCREENING SERVICES

NMAP covers mammograms and annual gynecological examinations when provided based on a medically necessary diagnosis. In the absence of a diagnosis, NMAP covers mammograms and annual gynecological examinations provided according to the American Cancer Society's periodicity schedule.

Telehealth: Mammograms are covered when provided via telehealth technologies subject to the limitations as set forth in state regulations, as amended.

Transmittal # MS-00-06

Supercedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-91-3

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

Community-Based Comprehensive Psychiatric Rehabilitation and Support Services Program

The following rehabilitative psychiatric services are covered as a comprehensive package of services under the Nebraska Community-Based Comprehensive Psychiatric Rehabilitation and Support Services Program:

1. Community Support;
2. Day Rehabilitation; and
3. Psychiatric Residential Rehabilitation.

The services must be medically necessary. These services are designed to rehabilitate individuals who are experiencing severe and persistent mental illness in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or nursing facility. Rehabilitative psychiatric services do not include treatment for a primary diagnosis of substance abuse.

Clients must be assessed by a licensed mental health professional prior to receiving these services. Based on the assessment, the licensed mental health professional will develop service need recommendations that identify rehabilitative and mental health/substance abuse services needed by the client. The completed service needs assessment and service recommendations will be reviewed and approved by a supervising mental health practitioner (psychiatrist or licensed psychologist).

Provider Qualifications: Providers of rehabilitative psychiatric services must be certified by the Department of Health and Human Services as providers of community-based comprehensive psychiatric rehabilitation and support services. The providers must agree to contract with the Department to provide these services and must demonstrate the capacity to fulfill all contractual requirements. The provider must also complete a Medicaid provider agreement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

Community-Support is designed to:

1. Provide/develop the necessary services and supports to enable clients to reside in the community;
2. Maximize the client's community participation, community and daily living skills, and quality of life;
3. Facilitate communication and coordination between mental health rehabilitation providers that serve the same client; and
4. Decrease the frequency and duration of hospitalization.

Community Support includes the following components:

1. Facilitating communication and coordination among the mental health rehabilitation providers serving the client;
2. Facilitating the development of an Individual Program Plan (IPP) that includes interventions to address community living skills, daily living skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, substance abuse services, and other related areas necessary for successful living in the community;
3. Providing/procuring the necessary individualized rehabilitation and support interventions to address client needs in the areas of community living skills, daily living skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of relapse and control of symptoms, mental health services, and other related areas necessary for successful rehabilitation and living in the community;
4. Monitoring client progress in the services being received and facilitating revision of the IPP as needed;
5. Providing contact as needed with other mental health service provider(s), client family members and/or other significant people in the client's life to facilitate

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

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communication and client skill-building necessary to support the client in community rehabilitation; and

6. Providing therapeutic support and intervention to the client in time of crisis.

Day Rehabilitation is designed to:

1. Enhance and maintain the client's ability to function in community settings;
2. Decrease the frequency and duration of hospitalization. Clients served in this program receive rehabilitation and support services to develop and maintain the skills needed to successfully live in the community.

Day Rehabilitation includes the following components:

1. Prevocational services, including services designed to rehabilitate and develop the general skills and behaviors needed to prepare the client to be employed and/or engage in other related substantial gainful activity. The program does not provide training for a specific job or assistance in obtaining permanent competitive employment positions for clients;
2. Community living skills and daily living skills development;
3. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms;
4. Planned socialization and skills training and recreation activities focused on identified rehabilitative needs;
5. Skill-building in the use public transportation when appropriate; and
6. Services for clients for a minimum of five hours per day, five days per week. Specific service levels for each client will be individualized, based on client needs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - REHABILITATIVE SERVICES

Psychiatric Residential Rehabilitation is designed to:

1. Increase the client's functioning so that s/he can eventually live successfully in the residential setting of his/her choice, capabilities, and resources; and
2. Decrease the frequency and duration of hospitalization.

Psychiatric Residential Rehabilitation includes the following components:

1. Community living skills and daily living skills development;
2. Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms; and
3. Skill-building in the use of public transportation when appropriate.

A psychiatric residential rehabilitation provider must be licensed as a residential care facility, a domiciliary, or a mental health center by the Nebraska Health and Human Services System. The maximum capacity for this facility must not exceed eight beds. A waiver up to a maximum of ten beds may be granted when it is determined to be in the clients' best interests. Facilities under contract with the Nebraska Health and Human Services System prior to the approval of this plan amendment whose capacity exceeds the ten-bed limitation will be exempted from this requirement, except that bed capacity can never exceed 16 beds.
